

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21462**
Registrar's No. **5820**

FILED JUL 15 1949

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 4038 Garfield	
3. NAME OF DECEASED a. (First) William b. (Middle) Moore c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) July 1 1949
5. SEX MALE	6. COLOR OR RACE COL.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 1864
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY L	9. AGE (In years last birthday) 85
11. BIRTHPLACE (State or foreign country) MISS.		12. CITIZEN OF WHAT COUNTRY? 1	
13a. FATHER'S NAME LAWRANCE MOORE		13b. MOTHER'S MAIDEN NAME HANAH PHELPS	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME W. Moore ADDRESS 1120 1/2 N. Compton	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 2 days	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		DUE TO (b) Hypertensive Heart Disease	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) Generalized Arteriosclerosis	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 97			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 4500			
22. I hereby certify that I attended the deceased from 6-29 , 1949, to 7-1 , 1949, that I last saw the deceased alive on 7-1 , 1949, and that death occurred at 6 a. m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) James J. Hedrick, M.D.		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 7-1-49			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 7-6-49	
24c. NAME OF CEMETERY OR CREMATORY FATHER PICKSON		24d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY	
DATE REC'D BY LOCAL REG. JUL 5 1949		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS R.F. Walton 2707 St. Laddard	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Handwritten mark or signature

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Arthur L. Belliard

Licensed Embalmer No. 4221

P. O. Address 4049 St. Ferdinand

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.